Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
B1	Benefits	Are the MHPs responsible for full coverage for all CSHCS and Medicaid covered services
B2	Benefits	Please define any carve outs
B3	Benefits	For carve out items such as – orthodontia, respite care etc., please clarify MHPs role in assisting members getting access to these services? Is this handled through the CSHCS department?
B4	Benefits	For pharmacy related carve outs, will DCH provide information at the NDC level regarding carve out medications?
B5	Benefits	Please confirm if CSHCS members will be eligible for any additional benefits through the MHPs that are not currently provided to all existing MHPs members?
B6	Benefits	What funding mechanism will be used to continue the services by LHD and CMS that are not clinical but are vital to the success of this program
B7	Benefits	DCH was to share a list of DME and providers with MHPs. When will this be available?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
B8	Benefits	DCH reported that telemedicine services are used more frequently for this population? Can DCH share which providers are providing these services? Any special requirements for providing services?
B9	Benefits	Will CSHCS enrollees in MHPs still have access to the Children's Special Needs fund
B10	Benefits	Is MDCH expecting the plan to change the authorizations policies and procedures for this population?
B11	Benefits	Will qualifying diagnoses remain the same
B12	Benefits	Is this population voluntary or mandatory
B13	Benefits	Is FFS an option
B14	Benefits	Please provide more detail of data sharing and reporting requirements.
B15	Benefits	Please provide clarification on the training required for member services staff.
B16	Benefits	How will they be handled for open enrollment
B17	Benefits	Please provide further definition of availability of contact person (i.e. – 24/7, 5-7 days per week, clinical, etc.)

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
B18	Benefits	Can autoassignment of the PCP occur if we have had to autoassign the beneficiary into the health plan
B19	Benefits	What will be the requirement for PCP assignment, if the MHP is unable to reach the family or they are unwilling to make a selection? Do we auto assign the PCP at this point?
B20	Benefits	What information available on the CSHCS beneficiaries will be made available to the plans
CC1	Care Coordination Continuity of Care	Will CSHCS provide care plans (like they do for CSHCS age outs/graduates) at the time of enrollment?
CC2	Care Coordination Continuity of Care	While we understand the need for continuity of care, it is suggested the MHP allow to move the member to a contracted PCP within a set time frame. What would MDCH consider an adequate timeframe?
CC3	Care Coordination Continuity of Care	Please define what is meant by "when transition to a network provider is deemed safe". Is this when the provider determines it to be safe, or when the family member makes the determination?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
CC4	Care Coordination Continuity of Care	How long do we need to allow of network services/out of state services? For specialty and primary care? When can we transition into network?
CC5	Care Coordination Continuity of Care	Will DCH should convene workgroup of LHD and MHP reps to develop standard template coordinating agreement.
CC6	Care Coordination Continuity of Care	Multiple agencies are providing some form of care management/case management services, will DCH provide contact information for LHD CHSCS staff and CMS clinics for MHPs to develop relationships?
CC7	Care Coordination Continuity of Care	Will the health plans be required to develop care plans for each child when the LHD leaves this up to the family and does not maintain care plans on all children? Who is ultimately responsible for the care plan – the LHD or the MHP? How often does the care plan have to be renewed/reviewed? What elements are required in a care plan? Is there a statewide template available for plans to use
CC8	Care Coordination Continuity of Care	Will MHPs need care coordination agreements (like we do with the CMHs) for LHD and CMS clinics?
CC9	Care Coordination Continuity of Care	What type of oversight will the CSHCS department and OMA have on MHP utilization management activities? What is there role in this process?
CC10	Care Coordination Continuity of Care	DCH mentioned possible retrospective review of MHP denials for this population. How will this be handled?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
CC11	Care Coordination Continuity of Care	DCH mentioned monitoring of the referral process. Most MHPs do not require authorization/referral for specialty physician services. Is DCH referring to services that require plan referral/authorization?
CC12	Care Coordination Continuity of Care	What is the expectation for MHPs that do not require referrals for specialty care services? How are MHPs supposed to track referrals?
CC13	Care Coordination Continuity of Care	Will DCH require different timeframes for authorization decisions for this population?
CL1	Claims	Please define MHP claim responsibility for the MHP assigned members during conversion
CL2	Claims	Will there be a separate fee schedule rate specifically for CSHCS enrollment on the DCH website?
CL3	Claims	Please confirm that if the CSHCS member has primary insurance other than Medicare and is also enrolled into MHP, the claims will be considered COB?
CL3	Claims Payment	Would payment to Family Centered medical home provider be handled in the same manner as GME/HRA?
CL4	Claims Payment	If member is seeing non-contracted PCP, who gets the incentive payment?
CL5	Claims Payment	How are retroactive payments to the primary care providers who serve CSHCS enrollees handled?
CL6	Claims Payment	Is PMPM payment to the FCMH provider subject to Claims Tax?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
CMS1	CMS Clinics	Will DCH allow MHPs to authorize CMS visits? Will MHPs be required to pay in-network and out of network CMS professional claims? Is there a specific/unique place of service code reported on the claims for CMS clinic services?
CMS2	CMS Clinics	Will DCH develop a workgroup with MHPs and CMS clinics (like they did with the MIHPs) to develop a standard care coordination template to be used.
CMS3	CMS Clinics	When a member is being seen by multiple specialists at the CMS Clinics on the same day, will the medical doctor (MD, DO) submit encounter claim separately to the MHP? Will the non medical doctor (i.e. Nutritionist, Psychologist) submit encounter claim separately to the MHP also, and is this consider a separate payment?
CMS4	CMS Clinics	Please provide clarification for services providing during CMS clinic visit that MHPs will be financially responsible for payment. Are the these services limited to professional services provided?
CMS5	CMS Clinics	CMS Clinics that is based in the hospital or stand alone, what Type of Bill and/or Form Type will the facility claim be submitted on?
CMS6	CMS Clinics	Please confirm that in the event CMS Clinics submit claims directly to the MHP for CSHCS member enrolled in the MHP, the MHP will deny the claims?
CMS7	CMS Clinics	If a child sees a psychologist at the CMS clinic visit, does this count towards their 20 OP mental health visit benefit?
CMS8	CMS Clinics	Can DCH provide breakdown of CMS clinic utilization to identify high volume CMS clinics? By dollar amount? By encounter?
CMS9	CMS Clinics	Can DCH tell the MHPs which CMS clinics the member is enrolled in?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
CMS10	CMS Clinics	Should plans list these CMS clinics in our provider directories since they are only available to CSHCS beneficiaries?
CMS11	CMS Clinics	Do MHPs have to cover transportation provided to CMS clinic visits?
CMS12	CMS Clinics	Will DCH be including a similar requirement to work with the MHPs in the DCH-CMS contracts (similar to the Hospital Access Agreements?)
CMS13	CMS Clinics	Can MHPs participate in the CMS clinic visits? MHP case managers may want to be part of the team? Will CMS clinics be required to provide a copy of the care plan to the MHP?
CMS14	CMS Clinics	How will DCH handle CMS clinics that are not contracted with the MHPs and have not signed the hospital access agreement?
CON1	Contract Language	When will draft contract language be available for review?
CON2	Contract Language	When will MHPs need to make decision regarding participation?
CON3	Contract Language	If MHPs decides not to participate initially, can they request participation at a later date after 10/1/2012?
CON4	Contract Language	If MHP participates, are they required to provide services to CSHCS in all approved services areas?
COB1	Coordination of Benefits	On the Plan level, is there coordination of benefits with other insurance?
COB2	Coordination of Benefits	Would the Plan coordinate any pharmacy co-pays or is that a non issue?
CCRR1	Core Competencies Readiness Review	When will core competencies document be completed and provided to MHPs?
CCRR2	Core Competencies Readiness Review	When will we see tool used during readiness reviews?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
CCRR3	Core Competencies Readiness Review	When will readiness reviews occur?
CCRR4	Core Competencies Readiness Review	How much lead time with MHPs have to prepare for readiness reviews?
CCRR5	Core Competencies Readiness Review	Will MHPs have to provide documentation prior to readiness review?
CCRR6	Core Competencies Readiness Review	How long will readiness review last?
CCRR7	Core Competencies Readiness Review	When will MHPs get report on readiness review findings?
CCRR8	Core Competencies Readiness Review	Will MHPs have opportunity to appeal any negative findings on the readiness review?
CCRR9	Core Competencies Readiness Review	Will DCH be conducting a focus study on CSHCS enrollment for FY2013 compliance reviews?
CCRR10	Core Competencies Readiness Review	Will DCH be incorporating this into the annual compliance review?
D1	Data	Please provide rate book – claims data used to develop rates
D2	Data	Will MDCH be providing a list of the pediatric subspecialists, children's hospitals, and pediatric regional centers?
D3	Data	Please provide a break down pharmacy costs into drug categories.

Frequently Asked Questions
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#	Category	Question
D4	Data	MHPs are required to have 90% of claims in network under the MI Compiled Laws. Please explain how MHPs are to meet this requirement if members are allowed to maintain their out-of-network providers.
D5	Data	Please provide utilization/cost breakdown by service category (i.e. inpatient, physician services, etc.)
D6	Data	Please provide cost and utilization data by diagnosis group by county/region.
D7	Data	Please provide cost and utilization data by provider type by county/region.
D8	Data	Please provide data on out of state utilization? By service? By provider type? By diagnosis group? By cost?
D9	Data	Will DCH provide breakdown of out of state services? By encounter and dollar amount? By service type? Who are key providers that MHPs will work with out of state?
D10	Data	Can DCH provide updated enrollment count by county? Last report provided was from November 2011.
D11	Data	Breakdown of CSHCS utilization by SNAF providers.
EL1	Eligibility	Will there be any changes to the MERF submission process for the MHPs for submitting a existing member for consideration for CSHCS eligibility?
EL2	Eligibility	Will a retroactive determination date be considered if the member expires after the MERF is submitted but before the determination date is determined
EL3	Eligibility	How will DCH's use of EZ-link impact the plans? Is this a function of CHAMPS? Will DCH providing EZLink training?
EL4	Eligibility	Will there be any changes to qualifying factors such as intensity of specialty treatment or severity of condition?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
EL5	Eligibility	There are many CSHCS eligible members currently enrolled in the plan, that have not completed an application to enroll, will these members automatically be enrolled into CSHCS at the implementation date of the project if the MERF was submitted within a certain timeframe (year?) If not, will the MHPs be required to submit an updated MERF to DCH for eligibility determination?
EL6	Eligibility	For the CSHCS transition, how will DCH handle retroactive eligibility after 10/1/2012 for the outstanding cases that have been submitted to DCH and are pending CSHCS eligibility determination or have been determined CSHCS eligible, but have not completed an application to enroll (especially NICU's) as there is a significant lag time? Will DCH retro-actively term the member for months prior to implementation and then leave them in the current Plan as of 10/1/2012? Will DCH still require an application for members determined eligible prior to 10/1/12?
EL7	Eligibility	Will MHPs be informed when CSHCS eligibility is expiring? What is redetermination process for CSHCS? Can MHPs assist in this process to ensure CSHCS eligible members have no "gaps" in eligibility? Will DCH request data from the health plans for redetermination, or will the plan have to track redetermination dates and submit the data?
EL8	Eligibility	For 10-15k look alikes currently enrolled in plans, but not enrolled in CSHCS, what will be process to get these members determined eligible and enrolled into CSHCS? Will DCH be hiring additional staff to process MERFs?
EL9	Eligibility	Will DCH be automating the MERF eligibility process? Will MHPs get more frequent reports of CSHCS eligibility status – to ensure appropriate capitation reconciliation?
EL10	Eligibility	Who will be the contact person for these eligibility submissions and inquiries?
EL11	Eligibility	Will the current age out process remain the same

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
EL12	Eligibility	Please confirm that families will no longer have to complete an application for enrollment in CSHCS. Please confirm that the child will automatically be enrolled into CSHCS at the time of CSHCS eligibility determination? Will the enrollment in CSHCS be retroactive to date of eligibility determination?
EL13	Eligibility	Please clarify the "opt out process". If there is an opt out of CSHCS for the family if the child is approved, how long does the family have to decide they do not want to be enrolled in CSHCS? What is the process for the family to communicate their desire to opt out?
EL14	Eligibility	It was mentioned the Office of Medical Affairs (OMA) office only has two staff members. Will the staffing be increased in order to meet the needs of the MHPs?
EL15	Eligibility	If the family decides to opt out of CSHCS, will the CSHCS eligible beneficiary who is currently enrolled in a MHP be disenrolled from the MHP and enrolled in FFS? Is this disenrollment retroactive back to date of eligibility determination?
EL16	Eligibility	The MHP is required to submit a completed MERF to the OMA within 30 days of receipt of an eligible condition. Does the OMA have a timeframe for responding to the MHP?
EL17	Eligibility	If the family decides not to opt out and remain in the MHP, when will the MHP receive the enhanced capitation rate? Will it be retroactive back to date of CSHCS eligibility determination? If so, what will be the process for capitation adjustments?
EL18	Eligibility	If the state has an 'opt out' process, and the family is notified of approval and their right to 'opt out' but they want to be in the program, is there a way for them to let the state know they do not want to 'opt out' or do they just have to not respond and then they will be automatically enrolled once the allotted 'opt out' time frame has expired?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
EL19	Eligibility	Recommend DCH evaluate the types of documentation needed for CSHCS eligibility and consider other documentation – such as plan utilization notes, case management documents, plans of care, etc. when determining medical eligibility.
EL20	Eligibility	The language requires a MERF be completed within 30 days of notification of the eligible condition or admission. What happens if notification is after 30 days?
EL21	Eligibility	Will there be any changes to the process for submitting MERFs within 30 days of birth for NICU babies?
EL22	Eligibility	What is the time frame for DCH to respond back to the eligibility submissions either in the pend, approved, or denied status?
EL23	Eligibility	Will there be any changes to retro disenrollment processes for NICU babies (going back to date of birth if MERF submitted within 30 days of birth) or for non-NICU cases being disenrolled back to the beginning day of the month in which the MERF was submitted if the family chooses to opt out?
EL24	Eligibility	Will all of the current diagnoses listed for potential CSHCS approval remain the same?
EN1	Enrollment	What is DCH doing about good contact information for these members?
EN2	Enrollment	Since DCH has decided to identify the CSHCS enrollment through a new provider ID for the MHP, will the MHP have to complete an enrollment form for this ID?
EN3	Enrollment	Will DCH consider allowing special disenrollment process for NICU babies born between cutoff deadline and 10/1/2012 effective date

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
EN4	Enrollment	With so much concern around this population, could a phase-in approach be considered, such as starting with an ASO arrangement with incremental increase in risk year to year, until full risk could be achieved?
EN5	Enrollment	How will this be displayed on CHAMPS? Will the CSHCS benefit information still appear in the same manner on CHAMPS?
EN6	Enrollment	How will the CSHCS begin date be communicated to the health plans? Currently a CSHCS member is retro termed on the weekly file. Are they still going to utilize this weekly file to notify us of CSHCS enrollment?
EN7	Enrollment	Will providers receive any notice/instruction on how to view CHAMPS screens once change occurs?
EN8	Enrollment	DCH stated that MHPs can include information about CSHCS in member communications/materials. If we include MDCH brochures – do these require approval? If the plan develops their own materials about the program, please confirm DCH will require approval
EN9	Enrollment	If member has Medicare coverage which capitation rate will MHPs receive – the dual rate or the CSHCS rate?
EN10	Enrollment	Will DCH be notifying MHPs of members aging out of CSHCS and MHPs still be required to do (part of person with special health care needs requirement in MHP contract
EN11	Enrollment	What will the policy be for plans that choose not to participate
EN12	Enrollment	How will they be identified on the enrollment and financial files
EN13	Enrollment	For non-participating plans, how will the State hold the plan harmless if there is a retro approval/disenrollment

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
EN14	Enrollment	Will MDCH be adding a flag for all CSHCS members in the 4276? Will that be in the same field as the 'pregnant' flag or will they create a separate field for that? Will this require a change to the 4276 file layout? Will MI Enrolls do some B2B testing?
EN15	Enrollment	Will MDCH be providing a flag on the 834 files (4976, 5012, and 5013) to identify the CSHCS enrollment? Will DCH send effective and term dates for CSHCS eligibility in the files? Is DCH planning on providing this information in the COB loops? If so, MHPs have concerns about data accuracy since we experienced have experience similar issues with the duals (i.e. invalid effective term/dates, confusing data, etc.) If that information is in that loop, will we receive a test files?
EN16	Enrollment	Will the companion guide be updated?
EN17	Enrollment	Can we anticipate reporting of the CSHCS children via the 4276 in advance of the program effective date (10/1/2012)?
EN18	Enrollment	Will DCH allow more time to match member with a PCP at the time of enrollment (instead of 30 day timeframe)?
EN19	Enrollment	Can MHPs include information about CSHCS eligibility in member communications/materials to promote the program benefits?
FI1	Family Input	How much involvement are MHPs expected to afford the CSHCS member and families in the policies and procedures of the plan?
FI2	Family Input	Please provide additional information on "CSHCS enrollees and families must be given the opportunity to provide input on Contractor policies and/or procedures that influence access to medical services or member services and information." What is the expectation on how Plans would meet this suggested requirement?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
FI3	Family Input	Can MHPs meet family input requirement through surveys and focus groups with CSHCS family members?
GA1	Grievance & Appeals	Will the guidelines and Turn Around Times for Grievances be the same as the existing process for Medicaid members?
GA2	Grievance & Appeals	Will members be able to appeal Non-covered benefit denials as well as other pre-service denials?
GA3	Grievance & Appeals	Will there be any changes in the Appeal process and guidelines?
GA4	Grievance & Appeals	How will the requests for Administrative Hearings be communicated and processed?
GA5	Grievance & Appeals	Is there such a process as “For Cause Disenrollments” for CSHCS?
GA6	Grievance and Appeal	Will DCH require plans to submit reports to DCH on CSHCS G/As. If so, will there be a revision to existing G/A forms or a new form created? When will these be available?
GA7	Grievance and Appeals	MHPs are already required to abide by strict state and federal guidelines for grievances and appeals. Will MDCH provide the guidelines required for this population?
MS1	Member Services	Will DCH be providing training for Health Plans member services staff? Is a contact phone number for a staff person trained on CSHCS on the website acceptable to meet this requirement?
OSS1	Out of State Services	Will MHPs be allowed to transition members back into state for on-going services?

Frequently Asked Questions
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#	Category	Question
OSS2	Out of State Services	What is the lodging and travel expenses related to out of state services? Please confirm MHPs are required to provide lodging/travel and meals for members and one guardian if child is a minor. What is the actual number of members receiving services out of state?
OSS3	Out of State Services	What type of services are provided out of state?
OSS4	Out of State Services	Will DCH notify the out of state providers about the enrollment change into MHPs?
OSS5	Out of State Services	Which providers refer out of state most often? Will DCH work with the MHPs to reduce number of out of state referrals (when services are available in state)?
P1	Pharmacy	How/when/with what frequency will the state update the drug carve out list for new drugs to the market?
P2	Pharmacy	Can the following information be provided: a. Brand vs. generic utilization b. Percentage of drug spend & utilization for specialty drugs c. Average dispensing fee per paid claim d. Average discount off of AWP for brand/generic/specialty
P3	Provider Network	What will the network standards be?
P4	Provider Network	Will MHPs be required to contract with new provider types?
P5	Provider Network	Will provider access standards be different for this population?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
P6	Provider Network	What do MHPs do if the PCP is not contracted with the MHP and does not want to contract with MHP? Can the MHP assign the member to another PCP, but allow access to the established PCP? Will DCH allow the MHP to have the member unassigned in our system in these situations?
P7	Provider Network	If plan demonstrates effort to contract in situations where provider is unwilling, will this meet the contract requirements during compliance review?
P8	Provider Network	What role will LHDs play in PCP selection? What does the Health Plan do if we cannot make contact with the enrollee/family to choose a PCP?
P9	Provider Network	Impact of non-par services for CSHCS members on OFIR in-network service requirements. Any update from OFIR?
P10	Provider Network	What is the State doing to educate pediatric subspecialists about the change?
P11	Provider Network	Can MHPs provide education about FCMH through provider manual and provider newsletters communications? Does DCH have a list of these providers? If not, we will need to survey providers to see which ones do this? Is there a certificate? Do we take the providers word for it?
P12	Provider Network	Does CSHCS have FCMH practices identified? If so it is requested DCH provide Plans with a list of these providers.
P13	Provider Network	Population appears to have high cost/utilization for DME and Home Healthcare. Will DCH share list of providers currently providing services to CSHCS members by county? This will help plan to enhance provider networks and limit out of network services?
P14	Provider Network	If MHPs have preferred provider arrangements with DME, lab, or HHC, can MHPs require members get services through these providers?
P15	Provider Network	How did the 3/21/12 meeting with the Pediatric and Children's Hospitals go? Any issues or concerns that MHPs need to be aware of?

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

#	Category	Question
P16	Provider Network	Will DCH provide list of high volume primary care sites providing services to CSHCS members? Again this information will help MHPs ensure adequacy of provider networks?
P17	Provider Network	Will DCH share CSHCS approved provider listing?
P18	Provider Network	DCH wants members to have PCP? Will Michigan ENROLLs be reporting PCP selection in enrollment files?
Q1	Quality	Will there be any different Encounter /Data Quality reporting requirements
Q2	Quality	Please identify the "specific performance improvement goals, objectives, and activities or interventions" which MDCH is requiring
Q3	Quality	When will DCH be providing plans with the draft FY2013 performance bonus criteria which will include CSHCS?
R1	Rates	Will the CSHCS rates have a bonus withhold
R2	Rates	How is DCH coordinating with OFIR regarding out of network payment
R3	Rates	Will capitation include initial hospitalization of premature infants?
R4	Rates	Will there be rate differentials for acuity and regions. (risk adjustments)
R5	Rates	Do we receive a cap payment on identified CSHCS diagnosis or do the members still have to be found eligible by an MDCH medical director
R6	Rates	When will the rates be available? What will timeframe be for comment period on rates? At the last Operations Meeting, DCH reported there would be a rate conference call scheduled? When will this be scheduled?

Frequently Asked Questions
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#	Category	Question
R7	Rates	MHPs will need to evaluate the CSHCS rates to make to evaluate participation. Will DCH provide MHPs with a "rate book" that provides same information (claims data, etc.) that Milliman used for rate development
R8	Rates	How will risk adjustment process work?
R9	Rates	DCH stated that they will be sharing multiple options for risk sharing levels in the rate development process. Will all plans be required to accept same option or can plans select individually?
R10	Rates	Sounds like travel and lodging is higher than typical Medicaid member – is this additional cost included in the rates?
R11	Rates	If CHSC members have primary commercial insurance, do we still get the higher capitation rate
R12	Rates	Has the State figured in the possibility of a higher utilization of transportation cost due to ease of accessibility (based on comments and experience with duals)? Costs may be higher than what the State has in their data base
R13	Rates	Please describe what happens if they are retroactively approved as it relates to capitation payment – will rates be adjusted retro-actively to the certification date

Frequently Asked Questions
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#	Category	Question
R14	Rates	Will DCH consider a higher administration percentage given that this population will require more coordination.
R15	Rates	When will a data book be published
R16	Rates	The managed care savings assumptions are too aggressive. What is the basis for the determination of the savings?
R17	Rates	When will rates be published
R18	Rates	40% of the physician cost is in “Other Professional” – what is included in this category?
R19	Rates	Please provide more detail re the State’s stop/loss proposal
R20	Rates	The two year experience in the cost model showed an **8.4%** trend for ABAD. Is the assumed trend in the rates for ABAD at 4.76% is too low.
R21	Rates	Please define financial reporting requirements
R22	Rates	What are the implications for the add-on components of the rates? E.g., SNAF

Frequently Asked Questions
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#	Category	Question
R23	Rates	Does the transportation amount include emergency transportation and airfare? If volunteer drivers are used, how was that portion of the transportation cost calculated? Transportation cost seems low; especially considering a large portion of transportation needed is "specialized," such as ambu-cabs and wheelchair accessible vehicles. There is $6.01 built in for TANF and $12.62 for ABAD
R24	Rates	Please provide a breakdown of the 10.75% load by component - administration/profit and contingency/contribution to surplus
R25	Rates	The claim probability distributions show 2% of ABAD participants had no claims and 25% had less than $1,000 of claims. These percentages are much higher than expected (resulting in lower claims cost estimate) given the qualification requirements of the program.. Please advise.

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
MHPs will be responsible for all Medicaid covered services covered by the contract with the exception of additional carve outs for CSHCS. MHPs will not be responsible for CSHCS-exclusive services: LHD care coordination, CMS clinic facility payment, Orthodontia provided for certain diagnoses, respite, insurance premium payment, and certain over-the-counter medications			
All carve outs currently in the contract remain the same. Additionally, factor for Hemophilia and select orphan drugs will also be carved out as well as the CSHCS-exclusive services listed above. NOTE: CSHCS individuals receiving Private Duty Nursing will continue to be an excluded population.			
MHPs are required to assist the CSHCS enrollee in communicating with the CSHCS program to request these services			
DCH provided the complete list of the carved out medications with the NDC number. These drugs will be carved out for all of the plan's beneficiaries.			
The MHPs will not be required to provide additional benefits; however, CSHCS will provide the benefits listed above			
DCH will continue to reimburse the LHDs for care coordination services and CMS Clinics for the facility pay.			
As soon as it is available			

Answer			
Because the use of telemedicine is still in start up phase, the numbers remain small. However, CSHCS has a federal grant for the purpose of increasing access to telemedicine for children with special care needs in rural or underserved areas. Currently CSHCS partners with DeVos Children's Hospital and U of M Mott (discussions with Detroit Children's Hospital) on this effort with the following rural sites: In - place: Alcona Health Center, Alpena; Dickinson Pediatric Clinic, Iron Mt Upcoming: Partners in Pediatrics, PLC. ,Saginaw; Holland Pediatrics, PLC., Holland; Forest Hills Pediatric Associates, PC, Grand Rapids; Tawas/St. Joseph Pediatrics, Tawas City Stand-alone: Marquette Clinic MHPs have no special requirements beyond what is stated in published policy.			
Yes			
No			
Yes			
Mandatory			
Only in POC counties			
Contractors, CMS Clinics, and LHDs will be expected to share data to ensure coordinated care planning and data sharing, including but not limited to, the assessment, treatment plan and care coordination as well as MHP reporting requirements."			
DCH-CSHCS will develop the trainings and the trainings will reflect DCH and health plan experience as implementation and operation of CSHCS enrollment into managed care continues			
CSHCS enrollees will be handled like all other enrollees in rolling open enrollment			
The CSHCS specialist member services should be available the same hours as the member services for all enrollees.			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
MHPs must work to contact the family to get the family attached to the PCP of choice. If after 20 days of significant and documented effort, the health plan is unable to contact the family, the health plan should first work with the local department to obtain contact with the family. If this does not work, the health plan may assign the beneficiary to a PCP who has agreed to and is qualified to serve a CSHCS enrollee. The plan must follow up with a letter to the family with the PCP assignment and instructions with how to change the PCP. This will be a topic for discussion with the Care Coordination Subcommittee.			
The plan must work with the family and the member's care team to have an appropriate PCP assigned to the member. These members often see multiple providers, by working with the family, local health department, and the current providers, DCH is confident appropriate PCP may be chosen for all CSHCS enrollees. If after significant, documented effort, the plan is unable to contact the family or the care team to choose a PCP for the CSHCS enrollee, the plan may auto-assign a PCP that is qualified and willing to serve a child or youth with special health care needs. The plan must follow up with a letter to the enrollee with the name of the assigned PCP and instruction on how the enrollee may change PCPs.			
CSHCS working with the LHDs to make available the Plans of Care, prior authorizations, and authorized providers for the CSHCS individuals.			
If the LHD has prepared a care plan for the beneficiary, then the LHD will be required to share the care plan with the MHP. Not all LHDs have prepared care plans for all CSHCS beneficiaries. A process will be outlined in the Care Coordination Subcommittee to exchange information.			
DCH does not believe a time frame can be set. The determination to bring in network should be made collaboratively by the family, the child's Care Team and the plan			
This language has been removed. The determination to bring in network should be made collaboratively by the family, the child's Care Team and the plan			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
There is no set time period. The contract language requires: "enrollees should be allowed to remain with providers with whom they have an established relationship at the time of enrollment in the health plan. Contractors should work with the family and established providers to assure access to the most appropriate provider for the enrollee. Contractors are encouraged to seek contracts with providers with established relationships with CSHCS enrollees"			
This will be handled as part of the coordination of care subgroup			
Yes. Agencies must work together to develop a routine processes to assure that the plans and all agencies providing care share information to keep all members of the care team up to date.			
These questions are being addressed by the coordination of care subgroup and information will be provided as soon as the subgroup completes its work.			
Yes			
OMA will be participating in the annual compliance reviews. Additionally, MHPs are strongly encouraged to seek the guidance of OMA physicians in making prior authorization and service decisions for CSHCS enrollees. Neither, OMA nor CSHCS will have a routine operational role in MHP utilization management activities			
This language has been removed from the contract			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
Contract requires MHPs to track referral processes for CSHCS enrollees so that DCH may monitor the referral/approval process for CSHCS enrollees. If referrals are not required			
MHPs should monitor utilization and subspecialist services provided to ensure that the member is receiving access to needed services.			
No			
MHPs are responsible for claims for all members that remain enrolled in the plan. The timeline provided at the 6/27 Operations Workgroup Meeting shows specific dates for when disenrollment from MHPs will cease.			
CSHCS does not have special rates. CSHCS rates are exactly the same as Medicaid FFS rates			
Correct			
No. DCH will not issue technical guidance. Plans are responsible for developing a process to pay the pmpm to the CSHCS PCP of record.			
If the CSHCS enrollee care is being coordinated by non-contract PCP, then the non-contract PCP receives the incentive pmpm.			
The question is not clear. Why would a plan assign a PCP retroactively?			
Yes, it is and it has been accounted for in the rates.			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
Children being seen in CMS clinics must be allowed to continue receiving services at CMS clinics without prior authorization. MHPs are required to coordinate with CMS clinics regarding the services provided at the CMS clinic. Therefore, plans should be working with these providers to plan care rather than require prior authorization. MHPs must pay non-contracted providers providing services at CMS clinics at the Medicaid fee screen rate. Providers will use outpatient clinic (22) as the place of service code on the 837P for the provider billing since all CMS clinics are located in outpatient hospitals. CSM contacts will be provided to MHPs and updated regularly.			
DCH suggests that the health plans work with the coordination of care subgroup to develop common language to use for coordination agreements			
Each provider of a covered Medicaid service may bill separately. The CMS clinic will not submit a claim to the MHPs for facility services. The CMS facility payment made by CSHCS includes payment for all ancillary providers who are unable to bill directly			
Health plans are responsible for covered Medicaid services provided by covered Medicaid professionals performed at CMS clinics. These providers will bill the health plan directly utilizing the appropriate mechanism (e.g. 837). Health plans are not responsible for a facility fee for the services performed at the CMS clinic such as screening and care planning			
Professional Providers in CMS clinics will bill, as appropriate, on the 837P claim form. CSHCS will continue to cover the CMS facility fee. The CSHCS covered service is not claim-based billing.			
CMS clinics will not submit claims to MHPs for facilities fees. The CMS facility payment made by CSHCS is not a claim-based billing. MHPs should contact their contract manager if the plan receives a facility claim from a CMS clinic.			
If the psychologist bills separately for the service she provides, then the service can count toward the 20 outpatient mental health visit benefit.			
Data is not available at this time			
This data is not available in a format that can be shared with the MHPs.			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
If the MHP is contracted specifically with the CMS clinic, then the clinic should be listed in the provider file. Most MHPs will have a coordination agreement, not a contract, with the CMS clinic. Under these circumstances, the CMS clinic would not be listed on the provider file.			
Yes			
Yes			
This will be discussed as part of the collaboration required			
MHPs are encouraged to have contracts with the providers who provide professional services in the CMS clinics. If the MHP does not have a contract with the provider, the MHP must pay the professional services at the Medicaid FFS rate. MHPs will not be responsible for the CMS facility payment			
Draft language has been shared with the plans multiple times. Final language is expected to be available in late June or early July.			
DCH announced on June 1 that participation is mandatory for all MHPs			
DCH announced on June 1 that participation is mandatory for all MHPs			
Yes			
Yes, MHPs must coordinate benefits with primary insurance in the same manner for all MHP enrollees			
Under Medicaid Policy, CSHCS enrollees, even adults in CSHCS, have no co-payments. Plans are encouraged to implement this policy for CSHCS enrollees over 21 years of age.			
Core competencies were provided in April. The final version was provided on 5/7/2012			
DCH sent the tool to the plans on 5/7/2012; the core competency document is the tool that IHC will use for the readiness review. There is no scoring. The criteria is present or not present.			

Answer			
June and July. MHPs must submit all materials for the readiness review by July 2			
MHPs must submit all materials for the readiness review by July 2			
Yes, as specified in the core competencies			
DCH will not be visiting the plans for the readiness review. Readiness reviews are documentation based. Plans' submissions will be reviewed at DCH.			
MSU Institute for Health Care Studies has agreed to turn the reviews around quickly. The goal is to have a decision within 2 weeks of plan complete submission of all required documentation and response to IHCS questions			
The need for appeals is not anticipated. IHCS will work with plans to clarify unclear documentation			
Yes			
No. Readiness review for CSHCS participation is completely separate from the annual compliance review. However, certain core competences are now in the contract or in the annual compliance review component			
This will be a part of the formal rate letter package			
This information has been provided			
This will be a part of the formal rate letter package			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
Upon discussion between OFIR and DCH, it appears that most MHPs are well below the required percentage. MHPs should monitor the impact of CSHCS out of network care on the percentage and make arrangements to meet the capital requirements if the percentage falls 90%. Any plans having a problem with capital requirements should contact OFIR.			
This will be a part of the formal rate letter package			
A county study including some diagnosis information was already provided to the MHPs. No additional work is planned for this item			
Other than the rate book discussed above, nothing additional will be provided for this item.			
A county study including some diagnosis information was already provided to the MHPs. No additional work is planned for this item.			
A county study including some of this information was already provided to the MHPs. No additional work is planned for this item.			
One of the county studies discussed above included updated member counts by county with age ranges. DCH will provide this updated monthly prior to the Operational Work Group meeting.			
Since CSHCS is not yet part of the SNAF logic, this would be too difficult to provide at this point in time			
For newly CSHCS-eligible individuals there will be no change to process; however, MHPs will be required to meet requirements for accuracy and completeness of medical information submitted			
Yes			
There is no change in this process for the MHPs. MHPs should continue to fax medical information to DCH (Jeanette) for at least the near future			
None expected			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
Current status in MHP will be maintained until implementation is finalized. A timeline for enrollment will be discussed at the 6/27 Operations Workgroup Meeting.			
The CSHCS managed care benefit plan does not begin until 10/1/2012; therefore, the increased capitation payment for CSHCS enrollees will begin on 10/1/2012 for all children determine retroactively eligible in the MHP with effective dates of prior to 10/1/2012.			
MHPs are required to assist with the renewal process. DCH has yet to finalize the process for informing the MHPs of CSHCS eligibility expiration dates, but the intent is to inform the plans in advance of eligibility expiration. The current processes under discussion include a carbon copy of the letter sent to the LHD or a monthly report to each health plan indicating the date of renewal for all CSHCS enrollees in the plan for whom CSHCS needs for updated medical information			
Effective 8/1, MHPs should begin submitting documentation on potentially eligible individuals per the instructions provided by DCH OMA on the 6/6 and 6/13 teleconferences.			
There is no change for the plans in this process. Please continue to fax the information to DCH (Jeanette). Enrollment in the CSHCS-MC benefit plan will be evident on the enrollment files.			
The process will not change.			
No. Individuals who age out of CSHCS will already be enrolled in the plans. The contract language for persons with special health care needs remain accurate.			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
Families will no longer need to complete an application. Once the beneficiary is determined to be medically eligible, the beneficiary will be automatically enrolled in CSHCS. The effective date of CSHCS benefit plan and movement to the CSHCS-specific capitation rate is explained in the timeline document distributed at the Operations Workgroup Meeting on 6/27.			
There is not an opt out process for CSHCS enrollment for individuals that are in the mandatory population for managed care. Once a child is determined medically eligible for CSHCS, the child is given the CSHCS benefit plan and must choose an MHP.			
DCH is currently addressing the staff needs and feels confident that OMA has resources necessary to assist the MHPs and make decisions in a timely fashion			
There is not an opt out process for CSHCS enrollment for individuals that are in the mandatory population for managed care.			
Most reviews are done in a timely fashion. Incomplete medical information from the MHPs is the most common reason that reviews are not completed timely. DCH has been working with the plans to better clarify the information that is necessary to make an accurate decision. Enrollment into the CSHCS-MC benefit plan/provider ID will be retroactive to the date of enrollment in CSHCS which will be retroactive to the date the condition is diagnosed or date of birth (in the case of a new infant)			
The effective date of CSHCS benefit plan and movement to the CSHCS-specific capitation rate is explained in the timeline document However, please note that there is not an opt out process for CSHCS enrollment for individuals that are in the mandatory population for managed care.			
There is not an opt out process for CSHCS enrollment for individuals in the mandatory population for managed care			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
DCH is developing written guidelines for the documentation needed in order to make eligibility determinations. DCH held two conference call explaining required documentation; please refer to this information.			
DCH has rewritten this language to allow health plans sufficient time to submit a complete MERF with ALL medical documentation necessary for OMA to make an eligibility decision. Time frames that exceed reasonable deadlines for submission of information may lead to a case-by-case review of whether retro-enrollment is reasonable.			
MHPs must submit complete documentation that meets the guidelines specified by DCH OMA as soon as the documentation becomes available.			
In most cases, OMA can make eligibility determination within 30 days of receiving complete information. OMA may occasionally need more than 30 days; however, the change in enrollment status will be retroactive.			
There is not an opt out process for CSHCS enrollment. The process for NICU babies will be discussed as part of the timeline distributed at the Operations Workgroup Meeting on 6/27.			
Yes, as of the time of implementation. CSHCS diagnoses coverage changes over time for various reasons.			
Typically, these enrollees are more in touch with case workers and LHD which allows access to good contact information. LHD can assist MHPs in contacting the family.			
The MHPs do not need to do any enrollments in CHAMPS. Some MHPs may need to send in the name of the person for whom they would like to be the domain administrator. If DCH is able to view the enrollment for the MA-MC, DCH will automatically assign the same person as the domain administrator for the new enrollment. DCH will contact each plan with the new provider IDs and indicate if a name and userid is necessary for the domain administrator.			
The timeline for enrollment will be discussed at the 6/27 Operations Workgroup Meeting.			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
DCH has evaluated a phased in approach and determined that phasing in this transition would add another level of complexity to this process. Additionally, many CSHCS families receive services at the major pediatric centers. Having only some CSHCS beneficiaries enrolled in managed care would be confusing for the families and facilities.			
The CSHCS-MC provider number will be displayed in the same manner as the MA-MC provider number for all other MHP enrollees in CHAMPS. Benefit plans information will appear the in the same manner as it does today. MHPs must use the correct provider ID when checking eligibility on CHAMPS. Authorized provider information is available on CHAMPS for CSHCS-MC enrollees.			
Yes, the retroactive term from MA-MC provider ID and enrollment into CSHCS-MC provider ID will both be communicated in the weekly file.			
Providers are receiving extensive information on the transition including viewing CHAMPS screens.			
The plans may use MDCH brochures without approval. As required by contract, DCH must prior approve any member materials developed by the plan.			
CSHCS members with Medicare coverage will be a voluntary population. If they choose to enroll in the plan, the enrollment will be under the MA-MC number and the plan will receive the dual rate.			
MHPs will get a report of individuals aging out of CSHCS and MHPs will still be required to ensure the transition from CSHCS-MC to MA-MC is smooth and access to care is assured.			
Please clarify question			
At this time, DCH believes that CSHCS enrollees will have a different provider ID; therefore, plans will be able to use this ID to track the members through enrollment and payment			
DCH announced on June 1 that participation is mandatory for all MHPs			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
MHPs can determine the CSHCS enrollees because they will be enrolled under the CSHCS-MC provider ID.			
CSHCS enrollees will have a different provider ID; therefore, plans will be able to use this ID to track the members through enrollment and payment.			
After further investigation, there will be no changes to the 834; therefore the companion guide will not be updated			
Enrollments will come to the health plans under the CSHCS- MC provider ID on the 4276 daily file as soon as the enrollments are completed.			
No			
Yes			
The Contractor must have an established mechanism to obtain input from CSHCS enrollees and families that should be included in written procedure. The input mechanism can take any form that gives the enrollees/families input into the Contractor policies and/or procedures that influence access to medical services or member services and information (e.g. prior authorization; out-of-network services). One suggested mechanism for gather input is forums for discussion between the CSHCS enrollees and families and the Contractor.			
Contractors are encouraged to develop forums for discussion between the CSHCS enrollees and families and the Contractor. Contractors may also seek family input through the establishment of a family advisory council, and/or the administration of surveys/questionnaires that solicit feedback on policies and procedures. Contractors should also be able to demonstrate that how the family input was utilized (i.e. provide documentation that demonstrates that the feedback was considered, and any changes that were implemented as a result of this feedback.)			

Answer			
Yes. Plans should work with DCH and discuss the types of input mechanisms under consideration. DCH will gladly provide assistance and direction on the best avenue for gaining family input.			
Yes			
Yes, same as for all MHP enrollees			
No, DCH will require MHPs to track grievance and appeals for CSHCS enrollees separately for at least the first year			
Same as for all other MHP enrollees			
Yes, same as for all MHP enrollees			
DCH may request information on the CSHCS grievance and appeals at any point in time after implementation and this data should be readily available for submission to the Department. This information will not be added to the quarterly grievance report.			
The guidelines for this population are identical to the guidelines for all MHP enrollees			
Health plans are required to pass along all information shared at meetings in order to train member services staff. DCH CSHCS staff is available for guidance and assistance on specific questions. DCH will review any training materials developed by plans, if this would be helpful. The contact number for the CSHCS specially trained staff person should be on the plan website as well as in the welcome letter for CSHCS enrollees. DCH will develop trainings for plans if plans indicate a need.			
This is no different than out of network services. The contract language requires: "enrollees should be allowed to remain with providers with whom they have an established relationship at the time of enrollment in the health plan. Contractors should work with the family and established providers to assure access to the most appropriate provider for the enrollee. Contractors are encouraged to seek contracts with providers with established relationships with CSHCS enrollees"			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
MHPs must provide lodging/travel, including meals, for CSHCS enrollees. MHPs must also provide lodging/travel and meals for one guardian if the member is a minor, is an adult with a legal guardian or has need of assistance in traveling. Data on out of state services has been provided			
Services that are not available in-state or have begun out-of-state and needs to be maintained with original provider (or in-state providers are unwilling to take beneficiary as a patient in the middle of a treatment plan.) A county study including some of this information was already provided to the MHPs. No additional work is planned for this item.			
Out-of-state providers are required to be enrolled with MI Medicaid and are to check beneficiary eligibility and enrollment prior to services as with any other provider. As MI Medicaid enrolled providers, these providers also receive Medicaid policy bulletins announcing this change.			
DCH is already working to reduce out of state referrals and will continue to do so.			
The carve out drug list will continue to be maintained by DCH and updated as new drugs are approved for Medicaid coverage			
DCH's ability to provide this information is still under investigation.			
DCH has added the following language for network standards to the contract: The Contractors network must include pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers that provide services to CSHCS enrollees.			
No			
No. However, MHPs should track access for this population separately for at least the first year			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
If the non-network physician continues to refuse to contract with the plan after several attempts, the plan may follow the contract provisions for transitioning the member to the in-network PCP. Additionally, the plan need not pay the FCMH payment to non-network physicians unwilling to discuss contracts or share information. Plan must maintain documentation of attempt to gather information and secure a contract.			
Yes and evidence that they are paying appropriately out of network.			
Because of the community-based nature of LHDs, LHDs may have access to more current contact information than DCH. LHDs will assist the MHPs in contacting the family to make a PCP selection.			
SNAF providers will not be considered in-network.			
DCH is developing communications and a communication plan for beneficiaries and providers. The Communication Subgroup Committee will report to the group at the Operations Work Group meetings.			
MHPs should focus on contract requirements for designating PCPs. DCH will provide additional information over time about FCMH.			
The practices that are PGIP or NCQA certified as PCMH are a subset of those that offer medical home functions for CYSHCN. So plans can begin with this list. This issue scheduled to be clarified at the 6/27 Operations Workgroup Meeting.			
Yes, DCH will provide a list of DME providers utilized most often for CSHCS beneficiaries. The high cost/utilization for home health is likely related to PDN. CSHCS enrollees receiving PDN will continue to be an excluded population.			
DCH expects that plans will not disrupt the coordinated care provided at comprehensive treatment sites. For example, plans may not require a family to take their child from an outpatient hospital to a special laboratory to have blood drawn and analyzed.			
A summary of this meeting was provided at the March Bi-Monthly operations meeting			

Answer			
This can be provided although the unusual role that specialists have in providing primary care to this population might be a study problem			
DCH has already sent the MHPs a list of current CSHCS-authorized providers.			
CSHCS enrollees must have a PCP; this is one of the major benefits of transitioning this population to managed care. When the member chooses a PCP at time of enrollment, the PCP choice will be on the 4276 daily file the same as all other MHP enrollees			
Same as for all other MHP enrollees CSHCS-specific quality measures may be developed in future			
DCH has not yet determined the specific performance improvement activities for this population. DCH will notify health plans in the usual process of any changes to Appendix 4 and/or Appendix 5 of the contract.			
Yes. The criteria for receiving the bonus award is complete implementation of all core competencies.			
Yes. The criteria for receiving the bonus award is complete implementation of all core competencies.			
SNAF providers will not be considered in-network.			
Yes			
There will not be rate differentials by region initially due to the relatively small number of CSHCS covered lives but this issue will be revisited annually based on the experience. There will be acuity risk adjustments every six months at the MHP level as there are now for the ABAD members			
Must be found eligible due to chronicity, severity and the need for a pediatric (except for adults) sub-specialist			
Draft rates were made available in mid-April. Plans requested a data book which was provided on 5/7/2012 along with revised draft rates. New rate versions have been created to respond to issues as they have arisen. The latest Milliman draft was dated June 8, 2012 and the final rates are expected to be very close to this version.			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
Milliman will provide this in the formal rate letter package.			
It will work the same way the ABAD risk adjustment process works. Although it is not clear yet whether CDPS or a different system will be used, the CSHCS members will be "rebased" once a year with the new MHP rebased risk score being applied in October of each year. Each MHP's CSHCS member mix will be reanalyzed in February-March and a new risk factor will be implemented in April of each year.			
All plans will be required to accept the same option.			
This issue has been discussed with Milliman, and the draft rates shared in mid-April accommodate these higher non-emergency transportation costs. The Department provided a combination of FFS data, ABAD encounter data and other relevant data to adequately address these additional costs.			
Any CSHCS members with another primary comprehensive HMO or PPO commercial insurance carrier will not be enrolled with an MHP. MHPs will get the CSHCS capitation rate for members with non-HMO or PPO other coverage.			
These costs have been considered in the rate development			
It is likely that rates will be adjusted retroactively to the CSHCS approval date for individuals that are new to the MHPs. For current MHP members that qualify for CSHCS enrollment, that higher utilization data is already part of the MHP rate analysis. Therefore, a downward adjustment to the MHP ABAD and TANF rates will probably be necessary when those CSHCS "hidden" members are transferred to the CSHCS rate cell. This question raises a number of technical issues which are still being analyzed.			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
No. Since administration is figured as a percentage of the base service costs and the base service costs for this population are very high, the usual percentage logic and amount results in an appropriate load for administration/profit/contingency.			
Data was sent 5/7/2012.			
Although this is more appropriately a question for Milliman, the savings logic is as follows: Normally, there is a managed care savings assumption of about 20% in the regular MHP rates with half of those savings being used to fund the MHPs' administrative/profit/contingency load. Therefore, the net savings to Medicaid assumption is about 10%. With the CSHCS rates, the managed care savings assumption has been reduced to about 13%. After adding back 10% for the admin/profit/contingency load, the net savings to Medicaid assumption is about 3%.			
The goal is to submit rates to CMS by July 1 for an effective date of October 1			
The most significant components in this line item would be therapies. The CSHCS members will have an unusually high utilization of therapy services.			
The detail is included in the draft rate exhibit. After receiving input from the plans, the decision was made to put the plans at full risk with no state-sponsored stop/loss arrangement. As a result, there will be no reduction to the capitation rate to fund a stop/loss pool.			
Milliman performs the trend analysis in the rates and MDCH supports the Milliman trend decisions.			
No change is expected here			
CSHCS fee-for-service experience in the Physician Adjuster Payment program will be analyzed so that the SNAF component of the MHP capitation rate can be enhanced (i.e. the funds will shift from FFS to managed care).			

Frequently Asked Questions
Enrollment of CSHCS Beneficiaries into MHPs

Answer			
1. Emergency ambulance transportation is not part of the Non-ER transportation line. Ambulance/emergency transportation will be priced into the Other Outpatient Hospital and Other Ancillary lines. 2. The issue of the costs of volunteer drivers was avoided by analyzing Logisticare encounter experience only. 3. An analysis was performed of encounters submitted for CSHCS clients by Logisticare in the metropolitan Detroit area. The TANF and ABAD pmpms thus far were about $2 and $8 respectively. We understand that non-emergency transportation costs will be somewhat higher in the rural areas but believe that the current loads of $6.01 and $12.62 are generous.			
Milliman responded that the usual breakdown logic exists with this rate as well: 9% if for administration and the remaining 1.75% is for profit/reserves/contingency.			
Some of the participants may have been active for only a few of the study months and would have had few or no claims. Also, many CSHCS members have relatively low acuity diagnoses that would generate a relatively small number of claims and dollars.			